

coverage, as well as when other interventions focusing on reducing health disparities in young adulthood are implemented.

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28.

IMPACT OF THE SCHOOL ENVIRONMENT ON RETENTION IN CARE AMONG HIV-POSITIVE YOUTH IN KISUMU, KENYA

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Purpose: Youth represent 40% of all new HIV infections in the world, of which 80% live in sub-Saharan Africa (SSA). In Kisumu, Kenya up to 57% of HIV+ youth may become lost to follow-up (LTFU) from care, placing them at increased risk for HIV-related morbidity and mortality. School going youth in SSA spend the majority of their time in school. We therefore explored the impact of the school environment on clinic retention among HIV positive youth in Kisumu, Kenya.

Methods: Qualitative data were collected in three stages. (1) Two Focus groups (FGs) (n = 18) were conducted with community health workers and HIV+ peer educators who work with LTFU youth. (2) Twenty-seven semi-structured interviews were conducted with HIV+ youth (15-21 years old) who had not received HIV care in four months or greater. (3) Ten in-depth interviews were conducted with educators selected from schools attended by LTFU interview participants. The domains of inquiry for all three stages explored school related barriers to following-up in HIV-care, the impact of the school environment on clinic retention, and possible school interventions to reduce LTFU. Transcripts were coded and analyzed employing grounded theory.

Results: There were five types of school-related barriers to follow-up. The majority of the barriers were influenced by HIV-related stigma in school. 1) Stigma & discrimination: HIV+ students experienced internalized stigma, perceived stigma, enacted stigma and discrimination in schools. 2) Disclosure: HIV+ students did not disclose their HIV status because they feared that the information would not be kept private and that teachers and peers would stigmatize them based on their HIV status 3) Educator beliefs: Educators lacked correct information about HIV, preventing HIV-positive students from feeling comfortable speaking to educators about personal issues. At times educators propagated stigmatizing beliefs about HIV that further isolated HIV+ youth. 4) School demands: Students did not attend their clinic appointments because of conflicting academic obligations, such as exams. 5) School excusal: Getting permission from school to attend clinic was difficult especially when school officials were not aware of a student's HIV status. Possible interventions proposed by participants included: 1) School education programs for teachers and students regarding HIV/AIDS and HIV-related stigma; 2) linkages between healthcare programs and schools to coordinate clinic appointments with school demands 3) formation of HIV-related school clubs to reduce HIV-related stigma; and 4) implementation of feeding programs that provide HIV-positive students with

nourishment while in school to aid with adherence to anti-retroviral therapy.

Conclusions: Many of the determinants of LTFU among HIV+ youth were related to stigma, which often was connected to reasons for lack of disclosure. Interventions focusing on reduction of stigma and increased disclosure of HIV status to trusted educators may improve HIV+ youth's retention in care.

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29.

PSYCHOSOCIAL PREDICTORS OF ADOLESCENT SEXUAL RISK BEHAVIOR: A QUASI-EXPERIMENTAL ANALYSIS IN A NATIONALLY REPRESENTATIVE SAMPLE OF AMERICAN YOUTHS

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Purpose: Previous studies have reported associations between psychosocial adjustment in childhood and sexual risk behavior during adolescence. While it is possible that exposure to these risk factors directly increases the likelihood of engaging in sexual risk behavior, an alternative explanation is that the observed associations between these variables are driven primarily by unmeasured confounds. We used a combination of quasi-experimental designs to examine whether these observed associations may be explained by genetic and environmental confounds not fully accounted for in previous research.

Methods: Participants were drawn from the Children of the National Longitudinal Survey of Youth, a longitudinal, nationally representative, and genetically informative sample in the United States (N = 7,743). Using a sibling comparison approach, we tested whether associations between measures of childhood psychosocial adjustment (i.e., early dating, substance use, and emotional and behavioral problems) and adolescent sexual risk behavior (i.e., early age at first intercourse and number of past-year sexual partners) remained after controlling for confounds shared by full siblings and maternal half siblings who differed in their exposure to each risk factor. Next, using quantitative genetic modeling, we also estimated the extent to which these associations were attributable to shared genetic, shared environmental, or nonshared environmental influences.

Results: In unadjusted analyses, each risk factor was significantly associated with greater likelihood of each measure of sexual risk behavior. The effects of nearly all predictors remained significant after controlling for measured covariates and after controlling for unmeasured familial influences shared by siblings, consistent with a causal influence. In contrast, our quantitative genetic models suggested that these associations were largely due to familial confounding, while the association between early dating and sexual risk behavior was attributable to shared genetic influences plus environmental influences specific to early dating. This pattern of findings suggests that even accounting for shared genetic and environmental influences using a sibling comparison approach—a rigorous alternative to traditional methods—may not provide sufficient control over potential confounds.

Conclusions: Common genetic and environmental influences may increase both the likelihood of exposure to psychosocial

risk factors and of engaging in sexual risk behavior. Studies unable to adequately account for these confounds may provide misleading support for a direct relationship between these variables. Our results suggest that prevention strategies aimed at reducing adolescent sexual risk behavior might need to address broader risk factors that contribute to both behavior

problems and a greater likelihood of sexual risk behavior. Additionally, early involvement in dating relationships may represent a causal risk factor for both early age at first intercourse as well as an increased number of sexual partners during adolescence.

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